Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INTEGRA SPECIALITY GROUP PA
5108 FOX CREEK TRAIL
DALLAS TX 75249

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

DALLAS NATIONAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 20

MFDR Tracking Number

M4-10-4929-01

MFDR Received Date

JULY 30, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "No EOB / Pre-Authorization 21975"

Amount in Dispute: $10,148.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review of the file, Carrier is processing and will pay all of the treatment listed as preauthorized on the DWC-60. However, with respect to the other items listed on the DWC-60, contrary to Requestor Integra Specialty Group's allegations, Respondent has made a valid and legal reimbursement, denial, or reduction of fees, under the Texas Department of Insurance, Division of Workers' Compensation (DWC) medical fee guidelines rules and statutes. Requestor's complaints involves dates of service July 31, 2009, August 4, 2009, August 7, 2009, August 10, 2009, August 17 2009, September 16, 2009, October 6, 2009, October 7, 2009, October 15, 2009, October 22, 2009, October 30, 2009, November 2, 2009, November 30, 2009, December 11, 2009, January 19, 2010, and March 8, 2010. Requestor alleges that no EOBs were provided for those dates; however, Carrier argues that they were provided. Copies of EOBs are attached hereto. Moreover, Carrier had a peer review performed on July 30, 2009, which indicated that 'no additional/future treatment as per the recommendations of the current ODG guidelines would be appropriate to threat this patient.' A copy of the 7/30/2001 Peer Review from R.A. Buczek, D.O., D.C. is attached. Finally, Requestor indicates that it should be reimbursed for dates of service August 17, 2009, August 18, 2009 and August 24, 2009 because the provider treated a compensable injury per a contested case hearing decision and order. However, the services provided were not reasonable and necessary as provided by Dr. Buczek's peer review report."

Response Submitted by: Lewis & Backhaus PC, 14160 Dallas Parkway, Ste. 400, Dallas, TX 75254

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2009 August 3, 2009 August 4, 2009 August 7, 2009 August 10, 2009	CPT Code 97032 (53.68 / 36.066) x $16.36 = $24.35 x 10 units =	$243.50	$243.50

July 31, 2009 August 3, 2009 August 4, 2009 August 7, 2009 August 10, 2009	CPT Code 97035 (53.68 / 36.666) x $11.65 = $17.33 x 5 units =	$86.70	$86.70
July 31, 2009 August 3, 2009 August 4, 2009 August 7, 2009 August 10, 2009	CPT Code 97110 (53.68 / 36.666) x $28.37 = $42.22 x 11 units =	$464.47	$464.47
July 31, 2009 August 3, 2009 August 4, 2009 August 7, 2009 August 10, 2009	CPT Code 97112 (53.68 / 36.666) x $29.05 = $43.24 x 5 units =	$216.18	$216.18
July 31, 2009 August 3, 2009 August 4, 2009 August 7, 2009 August 10, 2009	CPT Code 97140 (53.68 / 36.666) x $26.16 = $43.24 x 5 units =	$194.68	$194.68
July 31, 2009 August 3, 2009 August 4, 2009 August 7, 2009 August 10, 2009 August 17, 2009 August 24, 2009 October 15, 2009 October 22, 2009 November 2, 2009 November 30, 2009 November 30, 2009 December 11, 2010 January 19, 2010	CPT Code 99213 (53.68 / 36.666) x $61.76 = $91.92 x 12 units = CPT Code 99213 (54.32 / 36.8729) x $67.29 = $99.13 x 1 unit =	$1,106.05 $99.13	$0.00 $0.00
August 11, 2009	CPT Code 95831 (53.68 / 36.666) x $25.39 = $37.79 x 1 unit =	$37.79	$0.00
August 11, 2009	CPT Code 95832 (53.68 / 36.666) x $23.99 = $35.71 x 1 unit =	$37.71	$0.00
August 17, 2009 September 16, 2009 October 22, 2009 November 2, 2009 January 19, 2010 March 8, 2010	CPT Code 99080-73 $15.00 x 6 reports =	$90.00	$30.00
August 18, 2009	CPT Code 97750-FC (53.68 / 36.666) x $29.09 = $43.30 x 28 (each 15 minutes) unit =	$1,212.30	$0.00
August 31, 2009 September 1, 2009 September 2, 2009 September 3, 2009 September 4, 2009 September 8, 2009 September 9, 2009 September 10, 2009 September 11, 2009 September 14, 2009 September 24, 2009 September 25, 2009 September 28, 2009 September 30, 2009	CPT Code 97545-WH (15 Units) ($64 x 2 = $128.00 x 80% = $102.40 x 15 = $1,536.00	$1,536.00	$1,536.00

October 1, 2009			
August 31, 2009 September 1, 2009 September 2, 2009 September 3, 2009 September 4, 2009 September 8, 2009 September 9, 2009 September 10, 2009 September 11, 2009 September 14, 2009 September 24, 2009 September 25, 2009 September 28, 2009 September 30, 2009 October 1, 2009	CPT Code 97546-WH (90 Units) ($64 x 6 = $384.00 x 80% = $307.20 x 15 =	$4,605.30	$4,605.30
October 6, 2009 October 30, 2009	CPT Code 99212 (53.68 / 36.666) x $37.43 = $55.71 x 2 units =	$111.42	$0.00
March 8, 2010	CPT Code 99212 (54.32 / 36.8729) x $40.12 = $59.10 x 1 unit =	$59.10	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the procedures for preauthorization for certain services/treatment.
3. 28 Texas Administrative Code §133.305 sets out general medical provisions.
4. 28 Texas Administrative Code §134.203 sets out the reimbursement procedures for professional services.
5. 28 Texas Administrative Code §134.204 sets out the reimbursement procedures for workers' compensation specific services.
6. 28 Texas Administrative Code §129.5 sets out the requirements for Work Status Reports.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 18, 2009, September 22, 2009, October 14, 2009, November 3, 2009, November 12, 2009, November 23, 2009, December 9, 2009, December 14, 2009, February 19, 2010, March 23, 2010, March 26, 2010:

   - 1 (214) – Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.
   - 2 – (W1) – Workers Compensation State Fee Schedule Adjustment.
   - 1 – Unrelated to the compensable injury.
   - 1 – Charges for services not related to the Workers' Compensation injury.
   - 1 – 50 – These are non-covered services because this is not deemed 'medical necessity' by the payer.
   - 1 – Unrelated to the compensable injury.
   - 1 – A1 – Claim or service denied.
   - 1 – A1 – Claim/Service denied.
   - 1 – This item was previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice).
   - 1 – 96 – Non-covered charge(s).

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Is there unresolved extent of injury or unrelated to the compensable injury issues?

3. Is there unresolved medical necessity issues?
4. Did the requestor support Work Status Reports in accordance with 28 Texas Administrative Code §129.5?
5. Did the requestor obtain preauthorization for the physical therapy sessions in accordance with 28 Texas Administrative Code §134.600?
6. Did the requestor obtain preauthorization for the Work Hardening program in accordance with 28 Texas Administrative Code §134.600?
7. Is the requestor entitled to reimbursement?

Findings

1. The healthcare provider submitted the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307(c)(1).
2. Review of the EOBs, submitted by the insurance carrier representative, for the following: CPT Codes 97750-FC and 99080-73,for date of service September 16, 2009; CPT Code 99212, for dates of service October 6, 2009, October 30, 2009; CPT Code 99213, for dates of service October 15, 2009, October 22, 2009, November 2, 2009, and November 30, 2009; and CPT Code 99080-73 for date of service October 22, 2009 were denied for compensability. The compensability, extent, liability review for this dispute does not appear to have any compensability or extent issue and the insurance carriers' agent does not raise the issue in their response to the request for medical fee dispute resolution.

   Review of the EOBs submitted by the health care provider for CPT Codes 99213 for date of service August 17, 2009 and 97750-FC for date of service August 18, 2009 was denied for compensability; however, as stated in the previous paragraph, there does not appear to be any compensability or extent issue; nor is the issue raised in the insurance carriers' position statement; therefore this services are eligible for review.

3. According to the position summary The EOB submitted by the insurance carrier representative, for CPT Code 97750-FC for date of service October 7, 2009 denies the services as "1-50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer; the insurance carrier's representative also stated in the position summary that peer review performed on July 30, 2009, which indicated that "no additional/future treatment as per the recommendations of the current ODG guidelines would be appropriate to treat this patient." Review of the submitted dispute shows the health care provider performed three FCE's. Per 28 Texas Administrative Code §134.204(g) the following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements: (1) A physical examination and neurological evaluation, which include the following: (A) appearance (observational and palpation); (B) flexibility of the extremity joint or spinal region (usually observational); (C) posture and deformities; (D) vascular integrity; (E) neurological tests to detect sensory deficit; (F) myotomal strength to detect gross motor deficit; and (G) reflexes to detect neurological reflex symmetry. (2) A physical capacity evaluation of the injured area, which includes the following: (A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and (B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes. (3) Functional abilities tests, which include the following: (A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing); (B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices; (C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and (D) static positional tolerance (observational determination of tolerance for sitting or standing). Review of the FCE narratives submitted for each of the FCE's documents that these procedures were "medically necessary when such tests are needed to evaluate treatment or determine a patient's progress from baseline testing." The narratives did not document whether the FCE's were the initial test, interim test or the discharge test, nor were any of the FCE's ordered by the Division; therefore, the FCE's are subject to retrospective review. In accordance with 28 Texas Administrative Code §133.305(a) (7) Preauthorization or concurrent medical necessity dispute--A dispute that involves a review of adverse determination of network or non-network health care requiring preauthorization or concurrent review. The dispute is reviewed by an independent review organization (IRO) pursuant to the Insurance Code, the Labor Code and related rules, including §133.308 of this subchapter (relating to MDR by Independent Review Organizations).

CPT Codes 95831 and 95832 - The insurance carrier representative, in their position summary, raised the issue of medical necessity; as these codes do not require preauthorization they are subject to concurrent review. In accordance with 28 Texas Administrative Code §133.305(a) (7) Preauthorization or concurrent medical necessity dispute--A dispute that involves a review of adverse determination of network or non-network health care requiring preauthorization or concurrent review. The dispute is reviewed by an independent review organization (IRO) pursuant to the Insurance Code, the Labor Code and related rules, including §133.308 of this subchapter (relating to MDR by Independent Review Organizations).

CPT Codes 99213 and 99212 – The insurance carrier representative, in their position summary, raised the issue of medical necessity; as these codes do not require preauthorization they are subject to concurrent review. The Requestor billed CPT Code 99213 on eleven dates of service ranging from July 31, 2009 through January 19, 2010 and billed CPT Code 99212 on three dates of service ranging from October 6, 2009 through March 8, 2010; in accordance with 28 Texas Administrative Code §133.305(a) (7) Preauthorization or concurrent medical necessity dispute--A dispute that involves a review of adverse determination of network or non-network health care requiring preauthorization or concurrent review. The dispute is reviewed by an independent review organization (IRO) pursuant to the Insurance Code, the Labor Code and related rules, including §133.308 of this subchapter (relating to MDR by Independent Review Organizations).

4. In accordance with 28 Texas Administrative Code §129.5(d) The doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions; and (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee. The health care provider submitted 6 work status reports (CPT Code 99080-73) between August 17, 2009 and March 8, 2010; Review of the reports shows that the reports for August 17, 2009 and October 22, 2009 documented a change in work status; therefore, these two reports support reimbursement.

5. In accordance with 28 Texas Administrative Code §134.600(p)(5)(A) preauthorization is required for physical therapy. Review of the preauthorization approval documents the health care provider requested 12 sessions (3 times a week for 4 weeks) for physical therapy; the IMO Physician Advisor partially preauthorized medical necessity for 6 sessions of initial physical therapy on the cervical and bilateral shoulders. According to the insurance carrier's position summary, "After review of the file, Carrier is processing and will pay all the treatment listed as preauthorized on the DWC-60." The health care provider, to date, has not received payment for the preauthorized physical therapy. Review of the submitted documentation supports the services were rendered as billed. Therefore, reimbursement in accordance with 28 Texas Administrative Code §134.204 is due.

6. In accordance with 28 Texas Administrative Code §134.600(p)(4) preauthorization is required for all non-exempted work hardening or non-exempted work conditioning programs. Review of the preauthorization approval dated August 27, 2009 documents the health care requested five days a week for four weeks (160 hours) of working hardening. The IMO Physician Advisor partially preauthorized medical necessity for work hardening, 5 days a week for 2 weeks for a total of 80 hours. The health care provider requested additional sessions of work hardening for five times a week for 3 weeks (120). According to the preauthorization approval number 23394 the IMO Physician Advisory partially preauthorized medical necessity for work hardening for five times a week for one week (40 hours). In accordance with 28 Texas Administrative Code §134.204(h) The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier. (1) Accreditation by the CARF is recommended, but not required. (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR. (3) For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening. (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute

increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes. Review of the submitted work hardening narratives support the services were rendered as billed. Therefore, reimbursement in accordance with 28 Texas Administrative Code §134.204 is due.

7. Review of the submitted documentation finds that the requestor is due reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $7,377.03.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $7,377.03 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		June 25, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.